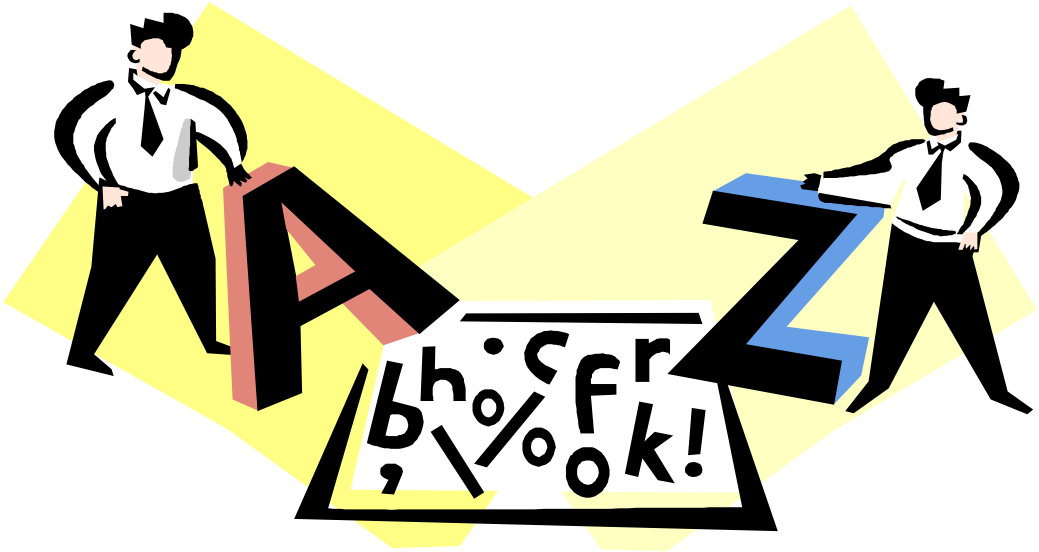
MONTANA
Department of Public Health & Human Services

How to Prevent Denials



Denial prevention starts with you!

- Check client eligibility every visit
- Stay up to date
  - Website, claim jumper, etc…
- Notice common denials
- Be proactive
  - Ask before billing

Verifying before submitting is easier than resending a corrected claim once it denied or adjusting a paid claim.

Top Denials

- Eligibility Denials
- Duplicate
- Passport
- TPL
- Medicare
- Prior Authorization
- National Drug Code (NDC)
- Rendering / Attending

Eligibility Denials

- Common denials:
  - Client not eligible for date of service
  - Client not eligible and has never been eligible
  - Client ID invalid or missing
  - Client not eligible for program being billed
  - Service limits exceeded

Prevention

- Check client eligibility every time prior to service
  - Different methods to check
    - Web Portal
    - Faxback
    - AVRS
    - Call Provider Relations (800-624-3958)

Understand the Types Eligibility

- Full
- Basic
- HMK (Healthy MT Kids)
- MHSP
- SLMB, QMB, and QI

MT Web Portal -Eligibility Inquiry Response - Windows Internet Explorer

https://mtaccesstohealth.acs-shc.com/mt/secure/eligibilityInquirySubmit.do

File Edit View Favorites Tools Help

Share Browser WebEx

MT Web Portal -Eligibility Inquiry Response

mt.gov
Montana's Official State Website

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Montana Access to Health Web Portal

Exit | Help

HOME INQUIRIES SUBMISSIONS RETRIEVALS MANAGE USERS MY ACCESS

Home > Inquiries > Eligibility Inquiry > Eligibility Inquiry Confirm > Eligibility Inquiry Response MT DPHHS

Eligibility Inquiry Response

Client Demographic Information

Client Original ID:	123456789	NPI or Provider ID:	1234567899
Client Current ID:	001111111	Date of Service:	02/15/2011
Client Member ID:	1111111	Valid Request Indicator:	
Name:	Test Data	Reject Reason Code:	
Address:	123 Main St	Follow-up Action Code:	
City:	Waterside	Date of Death:	
County Code:	25	Trace Number:	210000000100000000T
State:	MT		
Zip Code:	599990000		
Date of Birth:	01/01/2009		
Gender Code:	M: Male		

Eligibility Spans

About HMK/HMKPlus

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	Medicaid/HMKPlus	Full Coverage	09/01/2005	02/28/2011

Managed Care Information

Plan Coverage Description	Plan/PCP Name	Plan/PCP Phone Number	Begin Date	End Date
PASSPORT Provider	ST PETERS MEDICAL OFFICE BLDING	4064574180	04/01/2009	03/31/2011

Information Source Data

Done Internet 125%

start Inbox - Micros... 3 Windows E... 1: PITTSBURG... OmniTrack MT Web Portal... Web Portal.ppt DRAFT_2_spri... 2:25 PM

Full Coverage HMKplus

MT Web Portal -Eligibility Inquiry Response - Windows Internet Explorer

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HOME INQUIRIES SUBMISSIONS RETRIEVALS MANAGE USERS MY ACCESS

Home > Inquiries > Eligibility Inquiry > Eligibility Inquiry Confirm > Eligibility Inquiry Response MONTANA MEDICAID TEST1

Eligibility Inquiry Response

Client Demographic Information

Client Original ID:	123456789	NPI or Provider ID:	1234567890
Client Current ID:	009990000	Date of Service:	08/08/2011
Client Member ID:	9990000	Valid Request Indicator:	
Name:	Test Data	Reject Reason Code:	
Address:	100 Main St	Follow-up Action Code:	
City:	Somewhere	Date of Death:	
County Code:	01	Trace Number:	20100000000000000IT
State:	MT		
Zip Code:	599990000		
Date of Birth:	01/01/2011		
Gender Code:	M: Male		

Eligibility Spans

About HMK/HMKPlus

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	Medicaid/HMKPlus	Basic Coverage	08/01/2011	08/31/2011

Information Source Data

Basic Coverage HMKplus

Done Internet 100%

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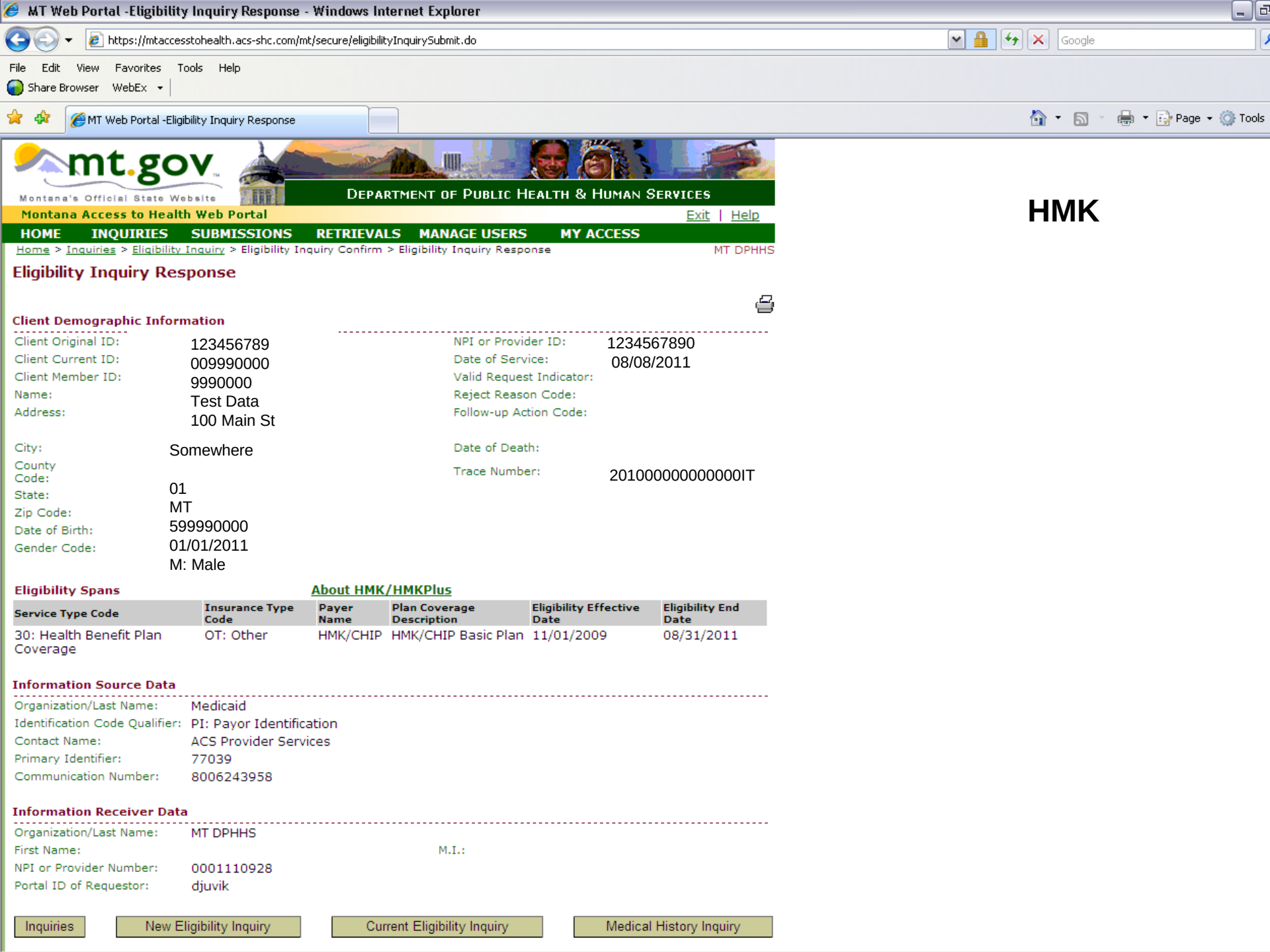
MT Web Portal -Eligibility Inquiry Response - Windows Internet Explorer
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File Edit View Favorites Tools Help
Share Browser WebEx
MT Web Portal -Eligibility Inquiry Response
Page Tools
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Montana Access to Health Web Portal
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HOME INQUIRIES SUBMISSIONS RETRIEVALS MANAGE USERS MY ACCESS
Home > Inquiries > Eligibility Inquiry > Eligibility Inquiry Confirm > Eligibility Inquiry Response
MT DPHHS
Eligibility Inquiry Response
Client Demographic Information
Client Original ID: 123456789
Client Current ID: 009990000
Client Member ID: 9990000
Name: Test Data
Address: 100 Main St
City: Somewhere
County Code: 01
State: MT
Zip Code: 599990000
Date of Birth: 01/01/2011
Gender Code: M: Male
NPI or Provider ID: 1234567890
Date of Service: 08/08/2011
Valid Request Indicator:
Reject Reason Code:
Follow-up Action Code:
Date of Death:
Trace Number: 2010000000000000IT
Eligibility Spans
About HMK/HMKPlus
Service Type Code | Insurance Type Code | Payer Name | Plan Coverage Description | Eligibility Effective Date | Eligibility End Date
30: Health Benefit Plan Coverage | OT: Other | HMK/CHIP | HMK/CHIP Basic Plan | 11/01/2009 | 08/31/2011
Information Source Data
Organization/Last Name: Medicaid
Identification Code Qualifier: PI: Payor Identification
Contact Name: ACS Provider Services
Primary Identifier: 77039
Communication Number: 8006243958
Information Receiver Data
Organization/Last Name: MT DPHHS
First Name:
M.I.:
NPI or Provider Number: 0001110928
Portal ID of Requestor: djuvik
Inquiries
New Eligibility Inquiry
Current Eligibility Inquiry
Medical History Inquiry

HMK

MT Web Portal -Eligibility Inquiry Response - Windows Internet Explorer

https://mtaccesstohealth.acs-shc.com/mt/secure/eligibilityInquirySubmit.do

File Edit View Favorites Tools Help

Share Browser WebEx

MT Web Portal -Eligibility Inquiry Response

mt.gov
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Montana Access to Health Web Portal

Exit | Help

HOME INQUIRIES SUBMISSIONS RETRIEVALS MANAGE USERS MY ACCESS

Home > Inquiries > Eligibility Inquiry > Eligibility Inquiry Confirm > Eligibility Inquiry Response MT DPHHS

Eligibility Inquiry Response

Client Demographic Information

Client Original ID:	123456789	NPI or Provider ID:	0001110928
Client Current ID:	009990000	Date of Service:	08/08/2011
Client Member ID:	9990000	Valid Request Indicator:	
Name:	Test Data	Reject Reason Code:	
Address:	100 Main St	Follow-up Action Code:	
City:	Somewhere	Date of Death:	
County Code:	01	Trace Number:	20100000000000000IT
State:	MT		
Zip Code:	599990000		
Date of Birth:	01/01/1944		
Gender Code:	M: Male		

Eligibility Spans

About HMK/HMKPlus

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	Medicaid/HMKPlus	Full Coverage	08/01/2011	08/31/2011
30: Health Benefit Plan Coverage	QM: Qualified Medicare Beneficiary	Medicaid/HMKPlus	Qualified Medicare Beneficiary	05/01/2008	08/31/2011

Medicare Information

Full Coverage
QMB
Medicare Part A & B
TPL

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Plan Coverage				
30: Health Benefit Plan Coverage	QM: Qualified Medicare Beneficiary	Medicaid/HMKPlus Qualified Medicare Beneficiary	05/01/2008	08/31/2011

Medicare Information

Insurance Type Code	Member Policy ID	Eligibility Effective Date	Eligibility End Date
MA: Medicare Part A	010000000A	01/01/2000	12/31/2099
MB: Medicare Part B	010000000A	01/01/2000	12/31/2099

Coordination of Benefits

1. Service Type Code: 30: Health Benefit Plan Coverage
   - Insurance Type Code: OT: Other
   - Carrier Code: S04
   - Insurance Co. Name: HUMANA
   - Address: P O BOX 14601
LEXINGTON KY 40512-4601
   - Group Policy Number:
   - Enrollment Date: 01/01/2000
   - Policy Number: 010000000
   - Expiration Date: 12/31/2099

Information Source Data

- Organization/Last Name: Medicaid
- Identification Code Qualifier: PI: Payor Identification
- Contact Name: ACS Provider Services
- Primary Identifier: 77039
- Communication Number: 8006243958

Information Receiver Data

- Organization/Last Name: MT DPHHS
- First Name: M.I.:
- NPI or Provider Number: 0001110928
- Portal ID of Requestor: djuvik

Inquiries | New Eligibility Inquiry | Current Eligibility Inquiry | Medical History Inquiry

Eligibility Inquiry Response

SLMB

Client Demographic Information

Client Original ID:	123456789	NPI or Provider ID:	0001110928
Client Current ID:	009990000	Date of Service:	08/08/2011
Client Member ID:	9990000	Valid Request Indicator:	
Name:	Test Data	Reject Reason Code:	
Address:	100 Main St	Follow-up Action Code:	
City:	Somewhere	Date of Death:	
County Code:	01	Trace Number:	20100000000000IT
State:	MT		
Zip Code:	599990000		
Date of Birth:	01/01/1944		
Gender Code:	M: Male		

Eligibility Spans

About HMK/HMKPlus

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	HS: Special Low Income Medicare Beneficiary	Medicaid/HMKPlus	Specified Low Income Medicare Beneficiary	06/01/2011	08/31/2011

Medicare Information

Insurance Type Code	Member Policy ID	Eligibility Effective Date	Eligibility End Date
MA: Medicare Part A	010000000A	06/01/2011	12/31/2099
MB: Medicare Part B	010000000A	06/01/2011	12/31/2099

Information Source Data

Organization/Last Name:	Medicaid
Identification Code Qualifier:	PI: Payor Identification

MT Web Portal -Eligibility Inquiry Response - Windows Internet Explorer

https://mtaccesstohealth.acs-shc.com/mt/secure/eligibilityInquirySubmit.do

File Edit View Favorites Tools Help

Share Browser WebEx

MT Web Portal -Eligibility Inquiry Response

mt.gov
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Montana Access to Health Web Portal

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HOME INQUIRIES SUBMISSIONS RETRIEVALS MANAGE USERS MY ACCESS

Home > Inquiries > Eligibility Inquiry > Eligibility Inquiry Confirm > Eligibility Inquiry Response MONTANA MEDICAID TEST1

Eligibility Inquiry Response

Client Demographic Information

Client Original ID:	123456789	NPI or Provider ID:	1234567890
Client Current ID:	009990000	Date of Service:	08/08/2011
Client Member ID:	9990000	Valid Request Indicator:	
Name:	Test Data	Reject Reason Code:	
Address:	100 Main St	Follow-up Action Code:	
City:	Somewhere	Date of Death:	
County Code:	01	Trace Number:	20100000000000000IT
State:	MT		
Zip Code:	599990000		
Date of Birth:	01/01/1985		
Gender Code:	M: Male		

Eligibility Spans

About HMK/HMKPlus

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	Medicaid/HMKPlus	Basic Coverage	08/01/2011	08/31/2011
30: Health Benefit Plan Coverage	OT: Other	MHSP	Mental Health Services Plan	04/01/2011	08/31/2011

Information Source Data

Basic Coverage and MHSP

Done Internet 100%

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MONTANA
Department of Public Health & Human Services

What you might see on your RA

- **Reason Codes**

  31 Patient cannot be identified as our insured

  177 Benefits for this time period have been reached

- **Remark Codes**

  N30 Patient ineligible for date of service

  MA61 Missing / Incomplete / Invalid social security number of health insurance claim number

```
1234567    Data, Test         07012011 07012011  1.000 99231 30.26  0.00      177 N30
   ICN 21122000000000000 PATIENT NUMBER=10000

     0000111111 Fred T Flinstone M D
                              07022011 07022011  1.000 99231 30.26  0.00      177 N30
                              07032011 07032011  1.000 99231 30.26  0.00      177 N30
                              07042011 07042011  1.000 99231 30.26  0.00      177 N30
                               ***CLAIM TOTAL*************** 121.04 0.00


****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE ******
N286   MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
N30    PATIENT INELIGIBLE FOR THIS SERVICE.
15     THE AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE
       BILLED SERVICES OR PROVIDER.
177    PAYMENT DENIED BECAUSE THE PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY
       REQUIREMENTS.
31     PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.
38     SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED NETWORK OR PRIMARY
       CARE PROVIDERS.
```

MONTANA
Department of Public Health & Human Services

How to Understand Reason & Remark Codes

- www.mtmedicaid.org
- Resources by Provider Type
- Other Resources
- EOB R&R Crosswalk

Forms
Health Improvement Program
Medicaid Fraud and Abuse
Medicaid Information
Medicaid News
National Provider Identifier
Nurse First
Passport to Health
Provider Locator Search
Provider Newsletters
Resources by Provider Type (manuals, fee schedules, notices, etc)
Site Map
Team Ca
Training
Upcoming Events
Web Links

Online Enrollment Tutorial
Online NPI Reenrollment Tutorial
Online Montana Access to Health Tutorial

Contact your software vendor and/or clearinghouse to make sure they are prepared to meet the deadline so that your claims processing is not delayed. For WINASAP users, a 5010-compliant version will be available later this year.

Watch for more details about plans for Montana Health Care Programs to be ready to accept and return transactions in the 5010 format and for other information related to 5010.

Health IT Environmental Survey

HealthShare Montana, Montana DPHHS, Health Technology Services, Montana Tech, and other Montana HIT entities need your assistance in completing an environmental survey.

This survey provides Montana with valuable baseline information required for:

- Quicker approval of state plans for release of HIT funds
- Better use of federal funds to assist HIT areas most in need
- Fewer state funds required to match federal funds
- More accurate picture of HIT landscape in Montana

vey is lengthy; therefore, we ask for only one completed survey per facility. Your quick response is important. Without an accurate survey, Montana will not be allocated its promised HIT funds.

The survey can be found at:
http://www.surveymonkey.com/s/MONTANASURVEY

Thank you for completing the survey. If you need a paper copy of the survey, contact Marcy Johnson at (406) 794-0170, Extension 1002, or mjohnson@healthsharemontana.org.

NEW PROVIDER ENROLLMENT OR EXISTING PROVIDER REENROLLMENT

MONTANA MEDICAID CLIENT INFORMATION

PROVIDER INFORMATION

Log in to Montana Access to Health

5010 HIPAA Information

Claim Instructions

Contact Us

Definitions and Acronyms

Early and Periodic Screening, Diagnosis and Treatment

Electronic Billing

Electronic Billing Companion Guides

Electronic Health Records Incentives

Physician

Provider Manuals (Updated July 1, 2011)
Medicaid Rules/Regulations (Updated May 9, 2006)
Fee Schedules (Updated February 2, 2011)
Archived Fee Schedules (Updated February 8, 2010)
Notices and Replacement Pages (Updated July 18, 2011)
Other Resources (Updated February 2, 2011)
Remitta Advice Notice
Key C Updated December 20, 2010)
Reba turers (Updated June 9, 2011)

Provider M

General Informa Providers
Medicaid billing mana eneral information for all provider types.
04/2005

Physician Related Services
This manual has billing instructions specific to your provider type.
07/2008

Mental Health Services - Adult
This manual has billing instructions specific to your provider type.
07/2011

Mental Health Services - Children

01/26/01
New Definitions for SED and SDMI

Back to Top

Other Resources

EOB R&R Crosswalk in PDF Format
EOB R&R Crosswalk [illegible]Excel Format
With the implemen[illegible]HIPAA, Medicaid will discontinue the use of Medicaid EOB codes and b[illegible]A standard reason and remark (R&R) codes. This document cross[illegible]ndard R&R codes to the Medicaid EOB codes.
02/2011

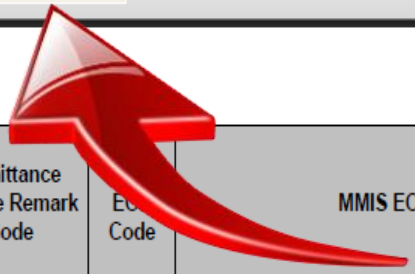
Service Matrix
Medicaid Mental Health Plan and Mental Health [illegible] Plan (MHSP) for Youth services excluded from simultaneous reimbursement
01/2011

Previous ATP Fees
2010 ATP tests and fee schedule
02/2010

Most Commonly Used NDCs
12/2009

Self Audit Policy and Procedure
04/2009

Carrier ID List
TPL insurance carriers listed by carrier ID
06/2007
Carrier ID List



Claim Adjustment Reason Code	Remittance Advice Remark Code	EO Code	MMIS EOB Description
4		7	The procedure code modifier listed on your claim is either invalid or the RBRVS payment rules do not allow this procedure to be billed
4		45	Modifier is invalid for the procedure code billed. Please correct and
4		215	Services denied. The modifier billed is invalid for the procedure billed. Please correct and resubmit.
4		479	Services denied. The assistant surgeon modifier is invalid for the procedure code being billed. Please correct either the procedure
4		482	Services denied. The modifiers billed for this service are not billable together. Please correct and resubmit.
4		890	Claim/line denied. Monaural hearing aids must be billed with "RT" or
4		896	Claim/line denied. Your claim does not indicate if the surgery performed was unilateral or bilateral. If the procedure was unilateral, please attach documentation of that to the claim and resubmit. If the procedure was bilateral, please attach a completed sterilization
4		953	Cardiac catheterization procedures performed in place of service "21" or "22", modifier "26" is required or a mental health procedure is being billed by a provider not authorized to bill the procedure.
6		63	The procedure you have billed is inconsistent with the recipient's age as listed on the Medicaid eligibility file or the recipient is not on the eligibility file. Check the procedure information provided on your claim for accuracy or verify recipient eligibility before contacting
6		143	Claim/line denied: revenue code is not valid for recipient's age.
6	N30	192	Services denied. Services are not covered for recipients over the
6		217	Claim/line denied. Iv sedation is allowed only for individuals who are twenty years of age or younger and when one of the following
6		258	Claim denied. Services billed on this claim are not covered when billed by this provider for MHSP clients 18 years of age and over.
7		101	Procedure is inconsistent with recipient's sex.
7		144	Claim/line denied: revenue code is not valid for recipient's sex.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
167		24	Diagnosis code is missing. Code with appropriate ICD-9-CM
167		70	Services denied. One of the following conditions exits related to the diagnosis code billed: the diagnosis code is not covered by Montana Medicaid, is invalid or may require additional digits. Please refer to your current ICD-9-CM code book. Contact ACS Provider Relations
167		71	Diagnosis code invalid/incomplete. Correct with ICD-9-CM-CM
170		65	Services denied. This provider type is not allowed to perform this
170		83	Provider specialty not allowed to perform this procedure.
170	N95	145	Line denied. This revenue code cannot be paid to this provider type. Please verify the accuracy of revenue code, provider number, and claim form used in billing. Resubmit on the correct claim form with
170		156	Claim/line denied. Mid-level practitioner providers may not bill for services with this procedure modifier.
171	M49	304	Claim/line denied. Dialysis services were either billed with the hospital provider number (adjust to change the provider number to the dialysis number) or the value code 68 was not present on the
173		127	Claim denied. Prescribing physician number invalid.
175		163	Claim denied. The prescription denial override code is either
175		272	Claim denied. Dispensed as written (brand needed) indicator is
175		273	Claim denied. The date the prescription was written is either
175		302	Claim denied. The prescribing physician field is either blank or invalid. Please review and resubmit the claim with a valid DEA
176		165	Claim denied. This drug has been discontinued.
177	N30	72	Claim denied. This individual's eligibility is not approved for this service. Please contact your eligibility technician for information
177		255	A provider type other than a PRTF provider has billed for services
177		256	A PRTF has billed services for a client that does not have a PRTF
177		259	Claim denied due to no Part B eligibility for professional or outpatient crossover claim and the client is QMB, SLMB, QI or Part
177	N30	260	Claim denied due to no Part A eligibility for inpatient crossover claim or client is QMB, SLMB, QI or Part A buy-in and no Part A on file.
181		64	Denied. This procedure code is not covered on the date of service billed. Please verify that a current procedure manual is being
181	M51	80	The type of service or procedure code is invalid. Refer to your provider manuals for details on valid procedure codes for your area of service. For CMS-1500 billers, please complete field 24c with a
181		85	For medical claims: there is no Medicaid fee on file for this date of service, or the procedure/type of service is not covered on the date of service. For pharmacy claims: the drug code is not covered on the date of service. For dental claims: the procedure billed is
181	MA66	385	Claim denied. The primary surgical procedure (ICD-9-CM-CM) code is invalid. Please correct and resubmit.
181	M67	386	Claim denied. One of the secondary surgical (ICD-9-CM-CM) procedure codes is invalid. Please correct and resubmit.
181		879	Claim denied. The surgical procedure code is invalid. Please code

Duplicate Errors

- What is a duplicate error?
  - Submitting a claim that has already been paid or for a similar service that has been paid
  - Different levels of duplicates cause denials

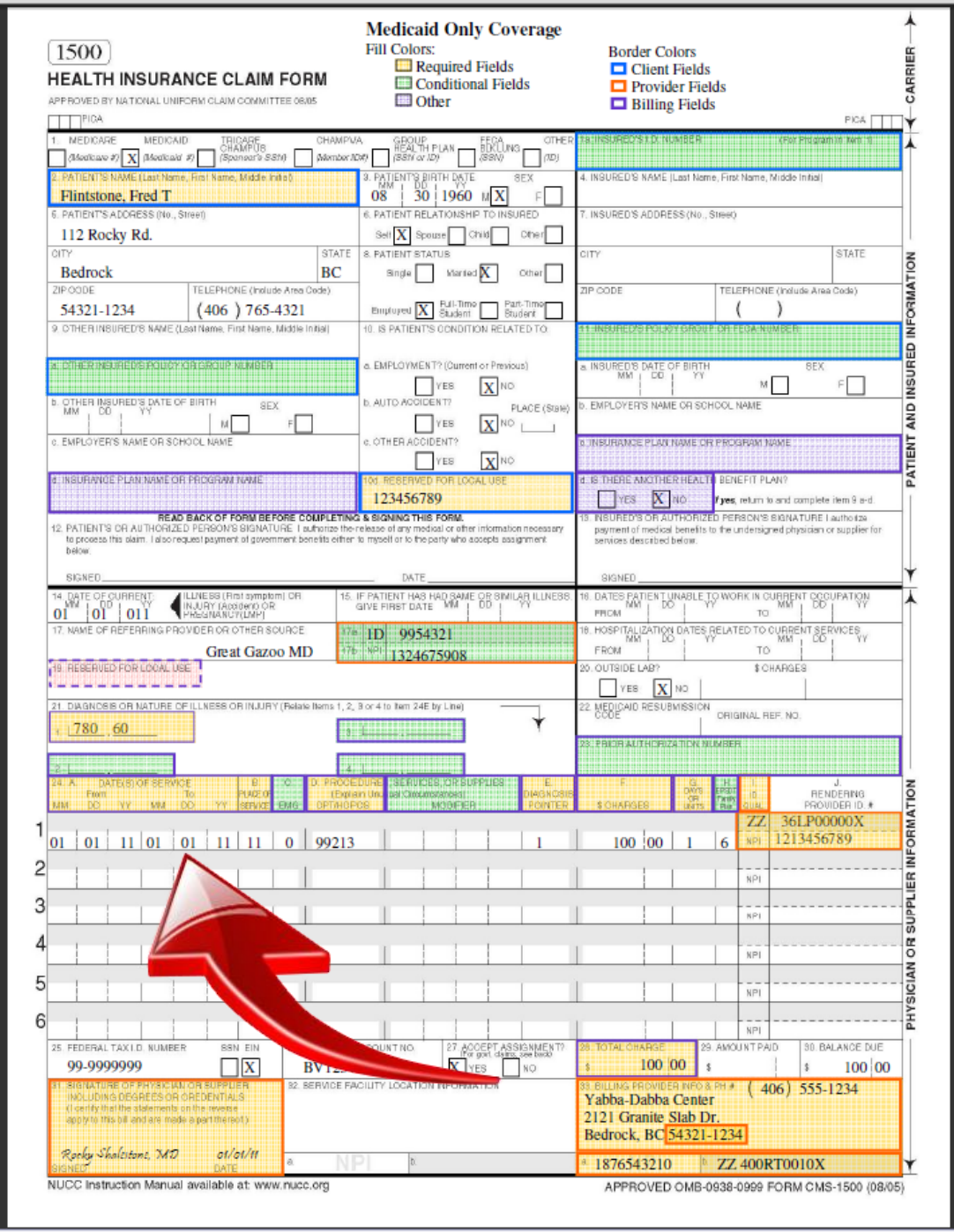
Three Kinds of Duplicate Denials

- Exact duplicate
  - You have already been paid for this service
- Suspect duplicate
  - Similar service, same provider, overlapping dates of service
- Duplicate Conflict
  - Similar service, different provider, overlapping dates of service

What to do

- Check claim status
  - Web portal
  - Call Provider Relations
- Check RA's
- Keep detailed records
- Bill appropriate modifiers when applicable

Exact Duplicate



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid Only Coverage

Fill Colors:
- Required Fields
- Conditional Fields
- Other

Border Colors
- Client Fields
- Provider Fields
- Billing Fields

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flintstone, Fred T

3. PATIENT'S BIRTH DATE: 08 | 30 | 1960 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 112 Rocky Rd.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock | STATE: BC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY | STATE

ZIP CODE: 54321-1234 | TELEPHONE (Include Area Code): (406) 765-4321

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

d. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 01 | 01 | 011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo MD

17a. ID 9954321

17b. NPI 1324675908

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 780 60

2.

3.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 11	01 01 11	11	0	99213		1	100 00	1	6	ZZ 36LP00000X NPI 1213456789
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO. BV12...

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Rocky Shalstone, MD 01/01/11

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (406) 555-1234

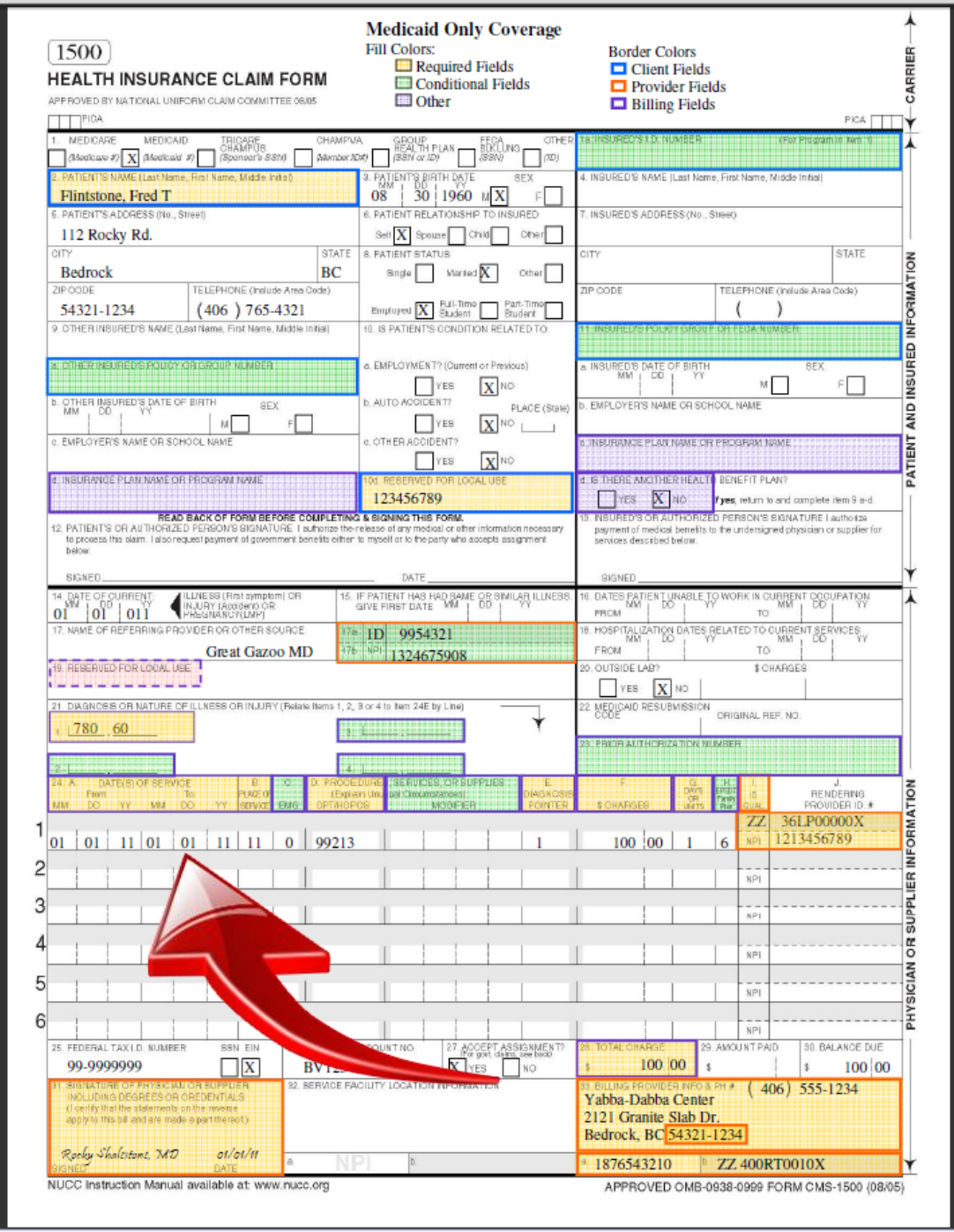
Yabba-Dabba Center
2121 Granite Slab Dr.
Bedrock, BC 54321-1234

a. 1876543210 b. ZZ 400RT0010X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Exact Duplicate



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid Only Coverage

Fill Colors:
- Required Fields
- Conditional Fields
- Other

Border Colors
- Client Fields
- Provider Fields
- Billing Fields

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flintstone, Fred T

3. PATIENT'S BIRTH DATE: 08 | 30 | 1960 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 112 Rocky Rd.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock | STATE: BC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY | STATE

ZIP CODE: 54321-1234 | TELEPHONE (Include Area Code): (406) 765-4321

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

d. INSURANCE PLAN NAME OR PROGRAM NAME

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10d. RESERVED FOR LOCAL USE: 123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

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Rocky Shalstone, MD 01/01/11

SIGNED DATE

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Suspect Duplicate

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock STATE: BC

8. PATIENT STATUS: Single [ ] Married [X] Other [ ]

CITY STATE

ZIP CODE: 54321-1234 TELEPHONE (Include Area Code): (406) 765-4321

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 123456789

d. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

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SIGNED

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17b. NPI 1324675908

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1 01 01 11	01 03 11	11	0	99213		1	100 00	1	6	ZZ NPI	36LP00000X 1213456789
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN EIN [X]

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27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 100 00

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Rocky Shalistone, MD 01/01/11

SIGNED DATE

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Yabba-Dabba Center
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Bedrock, BC 54321-1234

a. 1876543210 b. ZZ 400RT0010X

CARRIER

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Suspect Duplicate

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APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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CITY STATE

ZIP CODE: 54321-1234 TELEPHONE (Include Area Code): (406) 765-4321

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

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a. INSURED'S DATE OF BIRTH SEX

b. OTHER INSURED'S DATE OF BIRTH SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

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10d. RESERVED FOR LOCAL USE: 123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] If yes, return to and complete item 9 a-d.

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2										NPI	
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PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN [ ] EIN [X]

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27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 100 00

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30. BALANCE DUE: $ 100 00

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SIGNED DATE

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a. NPI b.

33. BILLING PROVIDER INFO & PH #: (406) 555-1234

Yabba-Dabba Center
2121 Granite Slab Dr.
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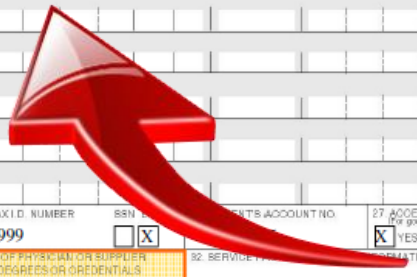
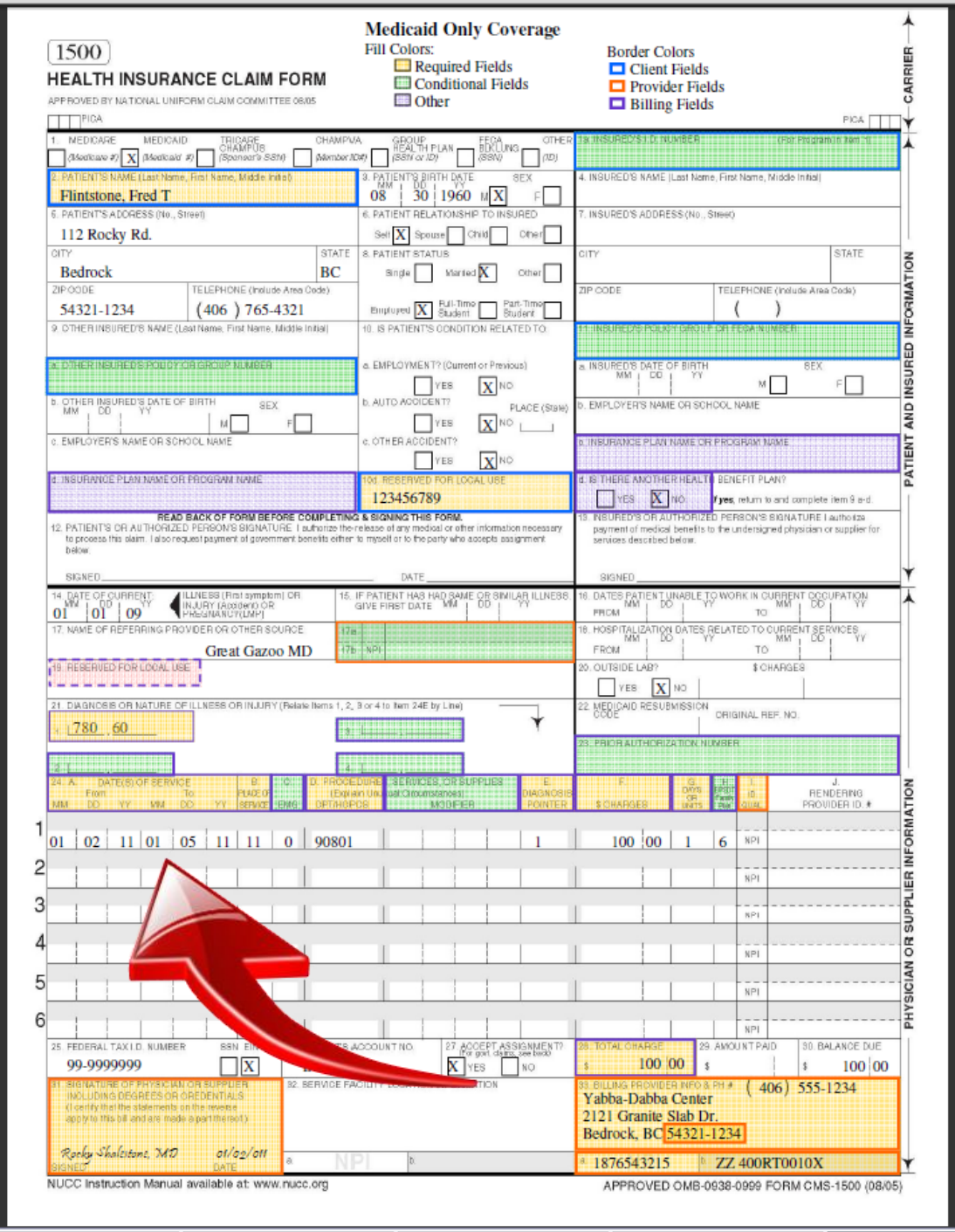


Duplicate Conflict



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid Only Coverage

Fill Colors:
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7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock | STATE: BC

8. PATIENT STATUS: Single Married [X] Other

CITY | STATE

ZIP CODE: 54321-1234 | TELEPHONE (Include Area Code): (406) 765-4321

Employed [X] Full-Time Student Part-Time Student

ZIP CODE | TELEPHONE (Include Area Code): ( )

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b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

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17b. NPI

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2121 Granite Slab Dr.
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a. 1876543215 b. ZZ 400RT0010X

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Duplicate Conflict

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CITY: Bedrock STATE: BC

8. PATIENT STATUS: Single Married X Other

CITY STATE

ZIP CODE: 54321-1234 TELEPHONE (Include Area Code): (406) 765-4321

Employed X Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

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11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES X NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO

If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP): 01 01 011

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo MD

17a

17b NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES X NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 780 60

3.

2.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 04 11	01 08 11	11	0	90801		1	100 00	1	6	NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN EIN X

26. PATIENT'S ACCOUNT NO. BV

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO

28. TOTAL CHARGE $ 100 00

29. AMOUNT PAID $

30. BALANCE DUE $ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Rocky Sholstone, MD 01/04/11

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a NPI b

33. BILLING PROVIDER INFO & PH # (406) 555-1234

Yabba-Dabba Center
2121 Granite Slab Dr.
Bedrock, BC 54321-1234

a 1987654321 b ZZ 400RT0010X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

MONTANA
Department of Public Health & Human Services

What you might see on your RA

- **Reason Codes**

  18 Duplicate claim / service

  97 Payment is included in the allowance for another service / procedure

  B13 Previously paid. Payment for this claim/service may have been provided in a previous payment

- **Remark Codes**

  M86 Service denied because payment already made for same / similar within set time frame

  M144 Pre- / Post-Operative care payment is included in the allowance for the surgery / procedure

  M15 Separately billed services / tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed

```
1234567    Data, Test         07012011 07012011  1.000 99221 204.00   96.66
   ICN 21122000000000000 PATIENT NUMBER=10000

     0000111111 Fred T Flinstone M D
                              07022011 07022011  1.000 59514 1900.00  0.00     B22  B13 M86 B15 M80
                              07032011 07032011  1.000 99231 93.00    0.00     B22
                              07042011 07042011  1.000 99238 154.00   0.00     B22


****THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE ******
B13    PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED
       IN A PREVIOUS PAYMENT.
B15    PAYMENT ADJUSTED BECAUSE THIS PROCEDURE/SERVICE IS NOT PAID
       SEPARATELY.
B22    THIS PAYMENT IS ADJUSTED BASED ON THE DIAGNOSIS.
MA04   SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR
       PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER
       NOT REPORTED OR WAS ILLEGIBLE.
M80    NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A
       PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.
M86    SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE
       WITHIN SET TIME FRAME.
N286   MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
107    CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE
       WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM
133    THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.
15     THE AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE
       BILLED SERVICES OR PROVIDER.
18     DUPLICATE CLAIM/SERVICE.
22     THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
9      THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE.
```

226	N29	859	This claim has been denied because the claim information indicates that an abortion may have been performed. If there was no abortion, please resubmit the claim with a statement signed by the
226	N206	860	Attachments do not correspond to claim with which they were ICN'ed. Removed and resubmitted.
226	N228	864	Consent form not completed correctly. Refer to the family planning section of your provider manual for instructions.
226	N362	875	Claim/line denied. The number of units billed for this service is more than the number of units that were authorized. Please correct the
226	N228	880	The recipient's date of birth on the consent form is inconsistent with that on the Medicaid eligibility file. To reconsider the claim, attach
226	N28	881	The person obtaining the consent did not sign, date or list their mailing address. Please correct and resubmit.
226	N517	883	Claim denied. Requested information has not been received.
226	N28	884	Claim denied. Physician must sign and date the physician certification section(s) on the abortion certification form.
226	N228	894	Claim/line denied. The sterilization consent form is incomplete. The date the procedure was performed is missing. All fields on the consent form must be completed for Medicaid to make payment.
226	N228	907	Claim denied. The date of the sterilization procedure under the physician's statement heading on the sterilization consent form is
A8		208	Claim denied. The procedure and diagnosis information provided on this claim cannot be assigned a correct DRG code. Please review diagnostic and procedure code information and correct if necessary. If correct, contact the Hospital Program Officer, Health Policy
A8		308	Claim first date of service is older than July 1, 1996 and will not group/price in our system. Please contact the Department with any
B13	M86	18	Claim or line denied. You may have already billed and been reimbursed for the same or similar service for this patient. Please check your records before resubmitting to the Provider Relations
B13	M86	100	Claim or line denied. This service or a related service performed on this date has already been billed by another provider and paid. Please verify the accuracy of the procedure code and the presence
B13		195	Services denied. Case management services have previously been billed and paid during this month.
B13	M2	201	Claim denied. The services for this claim are bundled in another

Passport Denials

- Passport referral is not present on the claim
- Passport referral number is invalid
- Incorrect Passport referral number for date of service
- How will I know if a client has a Passport provider?
  - Verify eligibility!
- What must I do to get the Passport number?
  - Call Passport provider for the referral

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Flintstone, Fred T

3. PATIENT'S BIRTH DATE MM 08 DD 30 YY 1960 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
112 Rocky Rd.

6. PATIENT RELATIONSHIP TO INSURED
Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY
Bedrock

STATE
BC

8. PATIENT STATUS
Single [ ] Married [X] Other [ ]

CITY

STATE

ZIP CODE
54321-1234

TELEPHONE (Include Area Code)
(406) 765-4321

Employed [X] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE

TELEPHONE (Include Area Code)
( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous)
YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? PLACE (State)
YES [ ] NO [X]

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT?
YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE
123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
YES [ ] NO [X]
If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM 01 DD 01 YY 09 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
Great Gazoo MD

17a. 1D 9954321

17b. NPI 24675908

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or

1. 780.60

3.

2.

4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #

Medicaid Only

Required Fields are Highlighted

1 Take Time Medical Center 104 Time Square Helena, MT 59601-0104	3a PAT. CNTL # 4806 b MED. REC. # Grisw97531 5 FED. TAX NO. 6 STATEMENT COVERS PERIOD FROM 02/01/09 THROUGH 02/01/09 4 TYPE OF BILL 131 7 9912345
8 PATIENT NAME a Pat.'s ID b Griswold, Clark	9 PATIENT ADDRESS a 1313 Mockingbird Lane, Metropolis, MT 59601-1313 b c d

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES	29 ACDT STATE	30
03/26/30	M	02/01/09	11		1		01			

31 CODE	OCCURRENCE DATE	32 CODE	OCCURRENCE DATE	33 CODE	OCCURRENCE DATE	34 CODE	OCCURRENCE DATE	35 CODE	OCCURRENCE SPAN FROM THROUGH	36 CODE	OCCURRENCE SPAN FROM THROUGH	37
a												
b												

38

Griswold, Clark
1313 Mockingbird Lane
Metropolis, MT 59601-1313

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	NDC	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	450	ER		90760	020111	4	3200 00		
2	636	Other Pharmacy N4 00409909332 UN 5		J3010	020111	1	620 00		
3	270	General Class Medical/Surgical Supplies			020111	110	583 00		
4	300	General Class Laboratory		81001	020111	4	500 00		
5									
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19									
20									
21									

MONTANA
Department of Public Health & Human Services

What you might see on your RA

- **Reason Codes**

  15 Payment adjusted because the submitted authorization number is missing invalid, or does not apply to the billed services or provider

- **Remark Codes**

  N286 Missing / incomplete / invalid referring provider primary identifier

4		953	Cardiac catheterization procedures performed in place of service "21" or "22", modifier "26" is required or a mental health procedure is being billed by a provider not authorized to bill the procedure.
6		63	The procedure you have billed is inconsistent with the recipient's age as listed on the Medicaid eligibility file or the recipient is not on the eligibility file. Check the procedure information provided on your claim for accuracy or verify recipient eligibility before contacting
6		143	Claim/line denied: revenue code is not valid for recipient's age.
6	N30	192	Services denied. Services are not covered for recipients over the
6		217	Claim/line denied. Iv sedation is allowed only for individuals who are twenty years of age or younger and when one of the following
6		258	Claim denied. Services billed on this claim are not covered when billed by this provider for MHSP clients 18 years of age and over.
7		101	Procedure is inconsistent with recipient's sex.
7		144	Claim/line denied: revenue code is not valid for recipient's sex.
9		60	The diagnosis on your claim is inconsistent with the recipient's age as listed on the Medicaid eligibility file. Check the diagnosis information you have provided for accuracy before contacting ACS
10		61	The diagnosis on your claim is inconsistent with the recipient's sex as listed on the Medicaid eligibility file. Check the diagnosis information provided on your claim for accuracy before contacting
11		3	Line denied. The diagnosis coding is incomplete or does not explain the medical reason for the service. Refer to the current ICD-9-CM book, and correct and resubmit the claim. If you feel the claim was coded correctly and want it reviewed, the following information must be sent: 1. Completed CMS-1500, 2. Operative report, 3. Office
11		245	Service denied. This service is inconsistent with the diagnosis
13		54	The recipient file indicates a death date prior to the date of service.
15	N286	41	Services denied. The service you provided requires authorization by the recipient's primary care PASSPORT provider. The PASSPORT authorization number is missing or invalid. Please obtain authorization, correct and resubmit. Effective 8/1/03 if this is an emergency room service, place of service 23, the diagnosis code is
15		150	Claim denied. The provider number on the claim and the prior authorization do not match. If possible, correct and resubmit.

TPL Denials

- Client has TPL
  - TPL not indicated on the claim
  - TPL amount not present on the claim
  - Claim information and EOB do not match
  - TPL denial does not contain reason and remark codes

- Claim indicates TPL
  - TPL indicator was checked or information was entered in the TPL section of the claim form
  - No EOB with Reason and Remark codes were attached

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Conditional Fields
Other
Provider Fields
Billing Fields

PICA

1. MEDICARE (Medicare #) | MEDICAID [X] (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Flintstone, Fred T

3. PATIENT'S BIRTH DATE MM DD YY: 08 30 1960 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)
112 Rocky Rd.

6. PATIENT RELATIONSHIP TO INSURED
Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock
STATE: BC

8. PATIENT STATUS
Single [ ] Married [X] Other [ ]
Employed [X] Full-Time Student [ ] Part-Time Student [ ]

CITY
STATE

ZIP CODE: 54321-1234
TELEPHONE (Include Area Code): (406) 765-4321

ZIP CODE
TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE
123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
[X] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT: MM DD YY 01 01 09 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
Great Gazoo MD

17a. 1D 9954321
17b. NPI 1324675908

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 780.60
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PATIENT AND INSURED INFORMATION

What to do

- Verify patient coverage
- Make sure to include copy of EOB's for denied or entire allowed to deductible claims by primary
  - Reason and remark codes included
- EOB's not required for claims that were paid by primary
- Notify ACS TPL of discrepancies for client coverage

MONTANA
Department of Public Health & Human Services

What you might see on your RA

- **Reason Codes**

  22 Payment adjusted because this care may be covered by another payer per coordination of benefits

- **Remark Codes**

  N245 Incomplete / Invalid plan information for other insurance

  MA04 Secondary payment cannot be considered without the identify of or payment information from the primary payer

16	MA64	827	This claim was denied because the patient has more than one insurance and only one EOB was attached. Please rebill the claim
16	MA130	828	Claim/line denied. Information on the claim form is not legible.
16	M119	844	This drug, dermal tissue, or blood product requires manual pricing by the physician services program. If the product has an NDC (national drug code), send in a copy of the claim and indicate the NDC and total amount given in field 19 of the CMS-1500 claim form. If product does not have an NDC, send in a copy of the claim along
16	MA122	905	Claim/line denied. A line level date of service on this claim is invalid. Please correct and resubmit.
16	N187	951	This procedure requires manual review. If this is an unlisted procedure code, make sure another code is not available. This procedure requires notes to substantiate medical necessity. Please send a copy of the claim and notes to: Medicaid Services Bureau,
18		1	This claim or line is being denied as a duplicate. You have already billed and been reimbursed for this service. Please check your
18	N75	94	Claim/line denied. More than one surface restoration code has been billed for the same tooth on the same day. Please correct the claim by coding for the total surfaces restored on the same day and
22	MA04	4	Based on the information you presented on your claim, the recipient appears to have other insurance coverage. Please indicate on the claim the amount paid by the other insurance or attach an insurance denial letter and resubmit the claim. If the patient doesn't have other
22	MA04	25	This claim has been denied for one or both of the following reasons: 1) the number of units appears to be excessive, or 2) the pricing and/or quantity indicates that an incorrect NDC may have been
22	MA04	36	Claim denied. The Medicare paid date is not present on the EOB or spread sheet received. Please resubmit with a complete copy of the Medicare EOB or spread sheet which includes the Medicare
22	MA04	47	Claim/line denied. Please resubmit the claim form with a copy of the Medicare explanation of benefits attached.
22	MA04	56	Our records indicate the recipient has Medicare coverage. Please submit the claim to Medicare for payment or resubmit the claim to Medicaid with either the Medicare information in form locators 39,
22	MA04	90	Claim denied. This recipient has third party insurance. Submit the claim directly to Montana Medicaid with documentation from the private insurance. Please refer to the claim denial above for details

Medicare Denials

- Medicare EOB and information on the claim do not match.
- Medicare denied requesting more information
- Claim is not on the Medicare EOB
- Medicare denied claim for a reason that Medicaid will not pay
- Medicare Reason and Remark codes are not present

What to do

- Verify patient coverage
- Resubmit corrected claim electronically

- If must bill on paper:
  - Include copy of Medicare EOB for all professional crossovers
  - Include copy of Medicare EOB for denied institutional crossovers
  - Medicare EOB is not required for institutional crossovers for paid or deductible

MONTANA
Department of Public Health & Human Services

What you might see on your RA

- **Reason Codes**

  22 Payment adjusted because this care may be covered by another payer per coordination of benefits

  177 Payment denied because the patient has not met the required eligibility requirements

  96 Non-covered charge(s)

- **Remark Codes**

  MA04 Secondary payment cannot be considered without the identify of or payment information from the primary payer

  N30 Patient ineligible for this service

  N192 Patient is a Medicaid / Qualified Medicare Beneficiary

DENIED CLAIMS - MEDICARE OUTPATIENT CROSSOVER

111101111 Data, Test 05182011 05182011 1.000 525 153.00 0.00 107 22 MA04
ICN 21100000000000000 PATIENT NUMBER=10001

*** MEDICARE PAYMENT***** 125.60
CLAIM TOTAL************ 153.00 0.00 107 22 MA04

OUR RECORDS INDICATE THAT THE RECIPIENT LISTED ABOVE HAS INSURANCE WITH

DENIED CLAIMS - MEDICARE OUTPATIENT CROSSOVER

BCBS OF MN

P O BOX 64338
ST PAUL, MN
55164

POLICY #: XZNXZ1111111 GROUP CERT #: RE200AI SUBSCRIBER SSN: 111-10-1111
SUBSCRIBER NAME: Data SUBSCRIBER INITIAL: S

RECIP ID	NAME	SERVICE DATES FROM	TO	OF SVC	UNIT PROCEDURE REVENUE NDC	TOTAL CHARGES	ALLOWED	CO-PAY	REASON & REMARK CODES

M86 SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.
N286 MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.
107 CLAIM/SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT PREVIOUSLY PAID OR IDENTIFIED ON THIS CLAIM
133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.
15 THE AUTHORIZATION NUMBER IS MISSING, INVALID, OR DOES NOT APPLY TO THE BILLED SERVICES OR PROVIDER.
18 DUPLICATE CLAIM/SERVICE.
22 THIS CARE MAY BE COVERED BY ANOTHER PAYER PER COORDINATION OF BENEFITS.
9 THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
167		24	Diagnosis code is missing. Code with appropriate ICD-9-CM
167		70	Services denied. One of the following conditions exits related to the diagnosis code billed: the diagnosis code is not covered by Montana Medicaid, is invalid or may require additional digits. Please refer to your current ICD-9-CM code book. Contact ACS Provider Relations
167		71	Diagnosis code invalid/incomplete. Correct with ICD-9-CM-CM
170		65	Services denied. This provider type is not allowed to perform this
170		83	Provider specialty not allowed to perform this procedure.
170	N95	145	Line denied. This revenue code cannot be paid to this provider type. Please verify the accuracy of revenue code, provider number, and claim form used in billing. Resubmit on the correct claim form with
170		156	Claim/line denied. Mid-level practitioner providers may not bill for services with this procedure modifier.
171	M49	304	Claim/line denied. Dialysis services were either billed with the hospital provider number (adjust to change the provider number to the dialysis number) or the value code 68 was not present on the
173		127	Claim denied. Prescribing physician number invalid.
175		163	Claim denied. The prescription denial override code is either
175		272	Claim denied. Dispensed as written (brand needed) indicator is
175		273	Claim denied. The date the prescription was written is either
175		302	Claim denied. The prescribing physician field is either blank or invalid. Please review and resubmit the claim with a valid DEA
176		165	Claim denied. This drug has been discontinued.
177	N30	72	Claim denied. This individual's eligibility is not approved for this service. Please contact your eligibility technician for information
177		255	A provider type other than a PRTF provider has billed for services
177		256	A PRTF has billed services for a client that does not have a PRTF
177		259	Claim denied due to no Part B eligibility for professional or outpatient crossover claim and the client is QMB, SLMB, QI or Part
177	N30	260	Claim denied due to no Part A eligibility for inpatient crossover claim or client is QMB, SLMB, QI or Part A buy-in and no Part A on file.
181		64	Denied. This procedure code is not covered on the date of service billed. Please verify that a current procedure manual is being

Prior Authorization Denials

- PA missing
  - No PA information was entered on the claim form
- PA invalid
  - Wrong PA entered for DOS
  - PA number does not match
  - Billed units or dollars exceeds approved
  - PA is used

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What to do

- Check the fee schedules prior to billing
  - www.mtmedicaid.org
- Call for a PA
  - Mental health 1-800-770-3084
  - Pharmacy 1-800-395-7961
  - Transportation 1-800-292-7114
  - All others 1-800- 262-1545
- PA's approved for units, dollars, or both

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What you might see on your RA

- **Reason Codes**

  15 Payment adjusted because the submitted authorization number is missing invalid, or does not apply to the billed services or provider

  198 Precertification / Authorization exceeded

  197 Precertification / Authorization / Notification absent

  125 Payment adjusted due to a submission / billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate

- **Remark Codes**

  N54 Claim information is inconsistent with pre-certified / authorized services

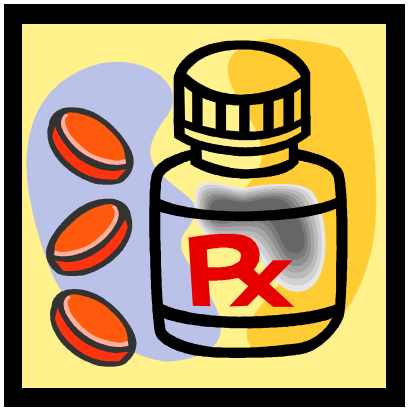
  MA06 Missing / Incomplete / Invalid beginning and/or ending date(s).

  M62 Missing / Incomplete / Invalid treatment authorization code

185		819	This recipient is on restriction to another provider. This service is not
197		9	Service denied. The prior authorization request for these services is pending. For assistance contact the approving agency.
197		57	Claim denied. State medical inpatient claims and certain outpatient surgical procedures require certification from "Managed Care Montana". Please attach the certification letter to the claim and resubmit it for processing. If you have no certification letter for this service, contact "Managed Care Montana" at 1-800-635-5271 for out
197		69	Claim denied. NDC requires prior authorization.
197		86	Claim denied. Diagnosis requires prior authorization.
197		142	Claim/line denied: revenue code requires prior authorization.
197		153	Service denied. The services authorized under this prior authorization were previously processed against this prior authorization record causing this record to be used and no longer
197	N45	474	Services denied. The change in the units or dollar amounts on this adjustment exceeds the authorized amounts, or this is an adjustment that was previously denied due to a problem with the prior authorization. Contact your approving agency for assistance
198		81	Service denied. The amount billed is greater than the amount authorized. For assistance contact the approving agency.
198	N54	113	Service denied. The number of units billed is greater than the number of units authorized or you are billing with a cancelled prior authorization number. For assistance, please contact the approving
198		170	This drug is outside the formulary and requires prior authorization. If you have not resolved this condition contact the drug prior
198	M62	866	Claim/line denied. At least one service on this claim requires prior authorization. Resubmit the claim with a valid prior authorization
211	M119	236	NDC required but is missing, invalid, not rebateable or DESI 5 or 6 or modifier 'KP' is on the line, indicating there should be an
211	N60	847	Drug claim denied. This drug has no price on file for the date filled. Either the NDC is obsolete or the manufacturer does not have a
216		169	Claim denied. Drug utilization review (DUR) reject error.
226	M53	6	The number of units billed in field #46 for accommodation days does not equal the number of days in the date of service span identified in
226	N3	73	The federal sterilization consent form or documentation of prior sterility is required, but was not present with the claim form. Please attach a copy of either the completed sterilization consent form or

National Drug Codes (NDC)

- What is a National Drug Code?
  - An 11 digit number in which the first five represent the manufacturer, the next four the product, and the last two represent the package size.
- What do we need to send with the National Drug Code?
- Where can I go to see if these are rebatable?



Denial Reasons

- NDC required but not present
- Invalid NDC
- Units missing
- Qualifier missing

What do we need to send with the NDC?

- N4 qualifier indicates NDC code
- Need unit of measure and unit qualifier
  - The NDC must be 11 digits long
- Shaded area on paper CMS 1500 claim form, above dates of service
- Form locator 43 on UB-04
- Loop 2410, segment LIN, data element 4; for electronic claims

Where can I go to see if this drug is rebatable?

- www.mtmedicaid.org
  - List of eligible drug manufacturer
- Under What's new or Resources by Provider Type
  - NDC assistance
- www.dmepdac.com/crosswalk/index.html

Preventing NDC Denials

- Use available resources
- Determine if rebatable
- Make sure all required info is there
  - N4 qualifier, unit of measure, unit dosage
- Call with any questions (800)-624-3958

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM 01 DD 01 YY 09 — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM _____ TO _____

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo MD

17a 1D 9954321

17b NPI 1324675908

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM _____ TO _____

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 780.60

3. _____

2. _____

4. _____

22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N4 00026064871 GR150													ZZ	36LP00000X
	01	01	11	01	01	11	11	0	J2250		1	100 00	1	6	NPI 1213456789
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER: 99-9999999 SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: BV12345

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 100 00

29. AMOUNT PAID $

30. BALANCE DUE $ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Rocky Shalestone, MD SIGNED 01/01/11 DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (406) 555-1234

Yabba-Dabba Center
2121 Granite Slab Dr.
Bedrock, BC 54321-1234

a. 1876543215 b. ZZ 400RT0010X

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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What you might see on your RA

- **Reason Codes**

  211 National Drug Code (NDC) not eligible for rebate, are not covered

- **Remark Codes**

  M199 Missing / incomplete / invalid national drug code (NDC)

  M123 – Missing / incomplete / invalid name, strength, or dosage of drug furnished

Preventing Attending, Rendering, and Pay-to Errors

- What to look for:
  - Attending billed on the UB-04 Institutional Claim
  - Rendering billed on the HCFA 1500 Professional Claim
  - Billing / Pay-to required on all claims regardless of type

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Attending, Rendering, and Pay-to Providers

- Attending providers:
  - See appendix for required attending
  - If not required do NOT bill attending
  - Loop 2310A, Segment NM1
  - Form locators 76, 77, 78, 79

- Rendering providers:
  - See appendix for required rendering
  - If not required do NOT bill rendering
  - Loop 2310B, Segment REF
  - Field 24L, 24J

- Pay-to providers:
  - CMS 1500 (Professional) = 33a (NPI) & 33b (Taxonomy)
  - UB-04 (Institutional) = 56 (NPI) & 81cc (Taxonomy)
  - NPI in Loop 2010AA, Segment NM1
  - Taxonomy code in Loop 2000A, Segment PRV

Attending, Rendering, & Pay-to Denials

- Possible denials reasons:
  - Attending or rendering billed but not required
  - Attending or rendering required but not present
  - Not billed with NPI, billed with Vendor #
    - Atypical providers bill with API #

Preventing Attending, Rendering, Pay-to Denials

- Verify Attending / Rendering relevancy
- Verify correct entry on claim form / e-claim
- Be sure to include taxonomy code
- Make sure the NPI is enrolled prior to billing

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What you might see on your RA

- **Reason Codes**

  16 Claim / service lacks information which is needed for adjudication.

- **Remark Codes**

  N290 Missing / incomplete / invalid rendering primary identify

  N257 Missing / Incomplete / Invalid billing provider/supplier primary identifier

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
16	N257	447	Healthcare providers must bill with a NPI.
16	N290	448	NPI is required for rendering healthcare providers.
16	N290	449	Provider type/specialty combinations which are not required to submit a rendering provider cannot submit a rendering which is
16	MA30	523	The bill type frequency of 4 or 5 is invalid. The provider must submit an adjustment to the original claim with the corrected charges.
16	MA30	524	The bill type frequency billed is a 2 or 3 and the Medicaid covered days is less than or equal to 30 days.
16		526	The cost-to-charge ratio is missing from the provider record. The claim will price once the provider record is updated.
16	N65	805	Line denied. An ancillary revenue code requires an accompanying surgical procedure code and date. Please complete the surgical procedure code with the date and resubmit an adjustment form to
16		820	Refill indicator must be either a "Y" or blank. Please correct the refill
16	MA64	827	This claim was denied because the patient has more than one insurance and only one EOB was attached. Please rebill the claim
16	MA130	828	Claim/line denied. Information on the claim form is not legible.
16	M119	844	This drug, dermal tissue, or blood product requires manual pricing by the physician services program. If the product has an NDC (national drug code), send in a copy of the claim and indicate the NDC and total amount given in field 19 of the CMS-1500 claim form. If product does not have an NDC, send in a copy of the claim along
16	MA122	905	Claim/line denied. A line level date of service on this claim is invalid. Please correct and resubmit.
16	N187	951	This procedure requires manual review. If this is an unlisted procedure code, make sure another code is not available. This procedure requires notes to substantiate medical necessity. Please send a copy of the claim and notes to: Medicaid Services Bureau,
18		1	This claim or line is being denied as a duplicate. You have already billed and been reimbursed for this service. Please check your


Questions?